Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(XI) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING	 	05/21	1/2013
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU		SS, CITY, STA MLEY PO I E, KS 6785	BOX 367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS			F 000			
	The following citations Health Resurvey.	s represent the findings	s of a				
	483.13(c) DEVELOP/ ABUSE/NEGLECT, E			F 226			
	policies and procedur	t, and abuse of residen					
	=	not met as evidenced to census of 21 resident	- 1				
	review, the facility fail policies and procedur mistreatment, neglect and misappropriation facility failed to train 1 the abuse, neglect, at The facility also failed compliance with Sect Security Act related to Suspicion of a Crime Facility", referenced in	t, and abuse of resident of resident property as of the 4 newly hired sind misappropriation pole to update policies to a ion 1150 B of the Sociation a Long-Term Care in the Survey and 30-NH, dated 6/17/11 a	ts the taff of licy.				
	Findings included:						
	•	ion on 5/15/13 at 9:40 a I performed housekeep m care unit.					
	N reported he/she wo the long term care un		r on				
LABORATOR	Y DIRECTOR'S OR PROVIDER	R/SUPPLIER REPRESENTATIV	/E'S SIGNATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		, ,	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
NAME OF PROVI	IDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE			
HODGEMAN	I COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
mitra mi of Du Ado the install production of Du St. Production of Du He the of The Mit that Ado Pot The mi	aining related to abusisappropriation of ref hire or in the 3 monuring an interview or dought that human restructed newly hired buse, neglect, and more reperty policy on the uring an interview or taff O reported according any interview or taff O reported according any interview or taff O reported according any interview or ousekeeping/Mainter elsacility's abuse, neglect, and more facility's abuse, neglect, and more facility failed to enter the facility failed to enter the facility failed to enter the facility failed to include accility's responsibilities.	rted he/she received not use, neglect, and esident property at the toths since his/her hire of the 5/15/13 at 3:45 p.m., g Staff O reported he/s esources staff trained at staff to sign a copy of hisappropriate of reside date of hire. In 5/16/13 at 12:55 p.m. reding to Administrative training from department of hire about the facility hisappropriation of residence of hire about the facility hisappropriation of residence of hire. Abouse, Neglect, and reperty" policy instructed will read and sign the Misappropriation of Promource newly hired staffied to abuse, neglect, and resure newly hired staffied to abuse, neglect, and	he nd the ent staff ent ty's dent of fation ed perty	F 226				

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

OLIVIEN	TOTAL MILLE TO THE CALL	EBIOT NE CEITTIGEC				- OND IN	0. 0000 0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SUI COMPLET	
		17E627		B. WING		05/2	1/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 226	requirements for report of a crime to local law. During an interview of administrative nursing facility Abuse, Neglect lacked the required in the Column of	orting reasonable suspice of a crime in a long termonal compliance with the current facility policy of a crime in a long termonal compliance with the corporate and implement on 1150 B of the Social or "Reporting Reasonab"	rent cy he S did not rm ent all al	F 226			
	The assessment must resident's status. A registered nurse must each assessment with participation of health. A registered nurse must assessment is completed in the complete seems of the assessment must significant portion of the assessmen	oth accurately reflect the set accurately reflect the set accurately reflect the set conduct or coordinate appropriate aprofessionals. Set sign and certify that set accurate appropriate	t the the acy of who	F 278			

subject to a civil money penalty of not more than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
	ROVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 278	\$1,000 for each asses willfully and knowingly to certify a material air resident assessment penalty of not more thassessment. Clinical disagreement material and false state and for review and false state a	ssment; or an individually causes another individually causes subject to a civil month and \$5,000 for each at does not constitute a tement. In other tas evidenced by a census of 21 residents of the consus of 21 residents of 2	dual ney by: s with s 1 of e te to ment re "on	F 278				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		17E627		B. WING		05/21/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	
HODGEM	AN COUNTY HEALTH	I CENTER LTCU		AMLEY PO RE, KS 678		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F R LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE COMPLETION
	revision date of 4/8/1 the resident to reposi needed to promote on pillows while in be on an air mattress. T staff to apply skin repcoccyx after each toil free of wrinkles, and		as neels t laid ted nd			
	included an order for bilateral feet.	3 admission physician c a dressing change dail				
	2/7/13 revealed resid right forearm, left elbe area on the left and re assessment also iden the right heel and the assessment lacked do of the areas of conce	ntified areas of concern e edge of the right foot. lescription or measuren ern on the buttocks and titled "Special Treatme	on The nents the			
	stated the resident had with a daily dressing note lacked identificathe red areas on the Admission Nursing A Resident #25's 2/15/to predict pressure ultimate the resident #25's 2/15/to predict pressure ultimates.	3 admission nurses' not ad a blister to the left he change. The admission ation and measurements buttocks identified on the ssessment. 13 Braden Scale (tool unlike for pressure ulcer	eel n s of ne			
	During an observatio	n on 5/9/13 at 1:40 p.m	.,			

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU		ESS, CITY, STA MLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 278	licensed nurse S whe hospital for a dressing the resident's coccyx. performed a dressing wound which had a w promote healing with measurements on the cm (centimeter) deep The wound measured wide. Another area or cm in length and 6.2 cricular area in center area measuring 0.7 crithe wound. During an interview or administrative nurse admission MDS lacked pressure ulcers present facility. He/she stated ulcers included a measuring the resident's heel. During an interview or administrative nurse of was made of the resident's heel. During an interview or administrative nurse of was made of the resident's heel. During an interview or administrative nurse of was made of the resident's heel. During an interview or administrative nurse of was made of the resident's heel. The facility failed to end the admission MDS asset the resident's skin control of the resi	eled resident #25 to the global change to the wound. Licensed nurse T change to the coccyx round vac (device used chronic wounds). Would coccyx wound revealed with a 2 cm of tunneling 3 cm in length and 1.8 on the right hip measurem wide with dark purper with an open superfice m by 1 cm in the center of the blister of the CAA for pressure assurement of the blister of the cocces	to and ed 1.5 ag. 3 cm ed 7.7	F 278				

4PWM11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	483.20(d), 483.20(k)(COMPREHENSIVE OF A facility must use the to develop, review an comprehensive plan of the facility must develop and for each resident objectives and timetal medical, nursing, and needs that are identificated assessment. The care plan must do to be furnished to attain highest practicable proposed by the facility and any series be required under §483.25; and any series be required under §483.10, including the under §483.10, including the under §483.10(b)(4). This Requirement is The facility had a cen residents selected for Based on interview and failed to use the result assessment to develop plan for former reside goals and specific interview and specific inte	1) DEVELOP CARE PLANS e results of the assessand revise the resident's of care. elop a comprehensive of that includes measurables to meet a resident's mental and psychosocied in the comprehensive escribe the services that in or maintain the resident or maintain the residency in the comprehensive escribe the services that would otherw 83.25 but are not provice exercise of rights under eright to refuse treatment of the comprehensive end record review, the falls of a comprehensive op an individualized carent #4, including measure erventions related to the	care able 's cial ve at are dent's vise ded - ent by: th 16 acility re rable	F 279 F 279	DEI IOIEIX			
	resident's hydration n Findings included:	eeus.						
		al record included phys						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 1	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		17E627		B. WING		05/2	21/2013
NAME OF PF	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279	diagnoses including " (change in level of coperson has partial arcawareness of his/her A 12/6/12 Annual MD identified resident #4 memory problems, making abilities, total ADLs (activities of daweight of 88 lbs (pour the mouth when drink dehydration. The 12/6/12 Annual M "Dehydration" for furth CAAs (care area assed Dehydration CAA datatrisk for dehydration condition and inability communicate if [he/shfluids with all meals encouragement Who changes [him/her] ever [he/she] will generally Resident #4's care plainterventions on 12/2 the resident's "potenti" "goal" for dehydration maintained as eviden [temperatures] over the plan lacked information temperatures related plan also directed staroom at all times, offer monitor vital signs we monitor for signs/symnotify the physician and all the physician and signs we monitor for signs/symnotify the physician and all times of the physician and signs we monitor for signs/symnotify the physician and signs we monitor signs/symnotify the physician and signs we make the signs we monitor signs/symnotify the physician and signs we monitor signs/symnotify the physician and signs we make the signs we monitor signs we make the signs we sig	persistent vegetative strusciousness in which a busal rather than true surroundings). S (Minimum Data Set) with long and short terroderately impaired decidependence on staff foily living) including eatings, a loss of liquids froing, and the presence of the system of	m ision or all ng, a om of e o the cother in the e will be mps care re in the etions, and	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		0	5/21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 279	interventions related to needs and how staff proffered the resident the "Hydration Assessme and 12/8/12 describer risk" for dehydration. A "Medical Nutritional progress note dated 9 #4's daily fluid needs centimeters) and averof fluid, a deficit of 65 A Nutritional Assessme calculated resident #4 cc's, with an average fluid, a deficit of 497 co. Nurses Notes included day time period from resident's #4's refusa 6:15 a.m. noted resident staff assistant Staff M also reported much fluids staff were resident, but stated the when they provided co. During an interview of Administrative Nurse care plan lacked a me and individualized interesident's specific fluiteresident's specific fluiter	to resident #4's specific blanned to ensure staff part amount of fluids dail ents" completed on 9/7/d resident #4 as "mode of Therapy" Quarterly 0/14/12 calculated resident as 1420 cc's (cubic rage daily intake of 762 8 cc's daily. Therapy of the folial entries of fluids. A 2/20/13 entert #4's death. The folial entries of the folial entries of the fluids. A 2/20/13 entert #4's death. The folial entries of the folial entries of fluids at fluids and dring the folial entries of the fluids and dring the folial entries of the fluids at meals entries of the fluids at the fluids at the fluids at the	ly. 12 rate dent 2 cc's 8/12 1023 2 of e 4 2d to try at nking. v s and 4's goal e o	F 279				

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

(X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ COMPLETED 17E627 B. WING 05/21/2013 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALTH CENTER LTCU 809 BRAMLEY PO BOX 367 JETMORE, KS 67854 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 279 F 279 Continued From page 9 According to the facility's "Hydration/Fluid Maintenance" policy, staff should develop an appropriate preventative plan of care and incorporate a hydration plan based on assessment, responses, outcomes and the needs of the resident. The facility failed to use the results of a comprehensive assessment to develop an individualized care plan for former resident #4, including measurable goals and specific interventions related to the resident's hydration needs. F 280 F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO SS=D PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs. and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This Requirement is not met as evidenced by: The facility reported a census of 21 residents with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	DER OR SUPPLIER COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
Fir I (mint see as lim was where rail base profits the per us Reference and Reference	review the facility failed and for 1 sampled resident and for the facility of the	in, interview, and record of to review/revise the object of the falls. O/13 Annual MDS evealed a BIMS (brief status) which indicated initive skills. The saled the resident requiled the resident requiled the resident requiled as walker and or the assessment furthed an upper extremited as eated to standing ing around, and was not surface transfer. It is same the resident has sessment. Care area assessment for the resident #10 had a history of the resident for the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are an also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and are also directed the status of the resident and a	care t fred ther ty y with ot ad no vith 10 of e falls, enswer aff to	F 280				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		1 ' '	LE CONSTRUCTION	(X3) DATE SU COMPLET	
		17E627		B. WING		05/2	1/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 280	weight, did not have to needed to support we assessment further resurpredictable and not follow commands. The the resident had conditional follow commands. The the resident had conditional follow lift with 2 start lift body lift lift body lift lift lift lift lift lift lift lift	the upper body strength eight during transfer. The evealed the resident was to cooperative or unable the assessment revealed ditions of dementia and assessment recommend of assist. Solves and Fall the following the ealed the following the ealed the following the ealed no evidence of a for causative factors of propriate fall preventional fall. Review of the clinical existing the ealed no evidence of a for causative factors of implementation that the falls. The ealed no evidence of a for causative factors of implementation that the ealed no evidence of a for causative factors of the preventional fall to prevent additional fall. The ealed no evidence of a for causative factors of the propriate fall preventional fall to prevent additional fall. Reviews the fall preventional fall to prevent additional fall. Reviews the fall preventional fall to prevent additional fall. Reviews the fall preventional fall to prevent additional fall. Reviews the fall preventional fall to prevent additional fall.	he as to d that to d that ded a g: ew of or or falls. ee fall ew or or or falls. eew or or or falls. either of or or or or falls. either of or	F 280			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER			LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E627		B. WING	·	05/2	21/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
HODGEM	AN COUNTY HEALTI	1 CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 280	the clinical record recassessment of the faimplementation of apstrategies after the faimplementation of apstrategies after the faimplementation of apstrategies after the faimplementation strategies after the faimplementation of apstrategies after the fairness after the fail risk and changes in resident and and pocument intervent overall care plan and and pivot transferciner in the aviary did not stand upright assist. The resident transfer. Observation on 5/9/1 direct care staff L and transferred resident to recliner using a staff to recliner using an interview of direct care staff K recrequired the use of a his/her wheelchair and while in bed. Staff fais transferred with a two staff. Direct care	vealed no evidence of all for causative factors of propriate fall prevention all to prevent additional by with a revision date of taff to: assessment and note an status. lisciplinary notes. tions to minimize falls of support the effectivene	n falls. If falls. If y n the ss of ed 10 to nt #10 ring ed hair dent o the the the the nn arm nt #10 of that that	F 280			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIES IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/21/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HODGEM	AN COUNTY HEALTH	H CENTER LTCU		AMLEY PO RE, KS 678		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETION
F 280	Continued From page	je 13		F 280		
	he/she tried to transfiplace to another.	er him/herself from one				
	licensed staff C rever when he/she experie used a personal body when in the wheelch C reported that resid	on 5/15/13 at 11:20 a.m aled that resident #10 for the conced delusions and that y alarm on resident #10 air or recliner. Licensed ent #10 had less falls silong term antibiotic for tract infection).	ell t staff t staff			
	The facility failed to review/revise resident #10's care plan with appropriate fall prevention strategies after multiple falls.		10's			
F 314 SS=D	483.25(c) TREATME PREVENT/HEAL PR			F 314		
	resident, the facility r who enters the facilit does not develop pre individual's clinical co they were unavoidab pressure sores receiv	ehensive assessment or must ensure that a resid y without pressure sore essure sores unless the ondition demonstrates the ole; and a resident having ves necessary treatment healing, prevent infection om developing.	ent s nat g it and			
	The facility reported	not met as evidenced be a census of 21 resident wand 1 resident review	s with			
	review, the facility fai reviewed for pressure treatment and service monitoring and meas	n, interview, and record iled to ensure 1 of 1 res e ulcers received neces es (a system for consist surements of wounds) in	idents sary ent 1			

r ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
	17E627			B. WING		05/2	1/2013	
			RESS, CITY, STA					
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	included multiple med weight loss, chronic (poften for the remainded pain syndrome, CHF output is low and the with fluid), dyspnea (concomfortable breath resulting from an excessing the body tissues), a (progressive mental of by confusion and mer Resident #25's 2/14/1 (Minimum Data Set) A resident had a BIMS status) score of 2 whi impaired cognition and of 2/7/13. The reside assistance of 2 persomobility, had no funct motion, and used a way According to the assessing the according to the composition of the resident develop pressure ulcassessment and form pressure ulcers present the observation period interventions included for the chair/bed and interventions to manage.	5/13 physician's orders dical diagnoses of include persisting for a long perser of a person's lifetime (a condition when the hoody becomes congest distressful sensation of ing), edema (swelling essive accumulation of and Alzheimer's disease deterioration characterizmory failure). 13 Admission MDS Assessment reported the (brief interview for mention indicated severely and an entry date to the first required extensive ans for transfers and bectional limitations in rangulational limitations in rangulational disease that may ance of less than 6 monospice services. The Millipresented as high risk ers based on the clinical and assessment tools with an admission or with dispressure relieving devinutrition/hydration	riod,) neart ted fluid e zed fluid facility d d le of d not y nths DS to al th no nin	F 314				

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E627 B. WING 05/21/201			21/2013			
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE			
HODGEM	AN COUNTY HEALTH	CENTER LTCU		MLEY PO RE, KS 678				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	Assessment revealed score of 6 which indici impairment. The resict assistance of 2 persomobility, had no funct motion, and used a water According to the assessment identified pressure ulcer develous unhealed pressure ulcer pressure ulcer that water assessment identified pressure ulcer that water assessment documstageable pressure ulcer that water assessment documstageable pressure as 4 cm (centimeters interventions included for the chair/bed, turn nutrition/hydration into application of dressin Resident #25's 2/19/1 (Care Area Assessment the resident was note [his/her] left heel that cm in diameter". The treatment orders and placed. Interventions clean and dry along waskin by the charge nunutrition/hydration, flod devices for bed/chair physician of any charmant in the score of the present of the charge nunutrition/hydration, flod devices for bed/chair physician of any charmant in the score of the charge nunutrition/hydration of the charge nunutrition/hydration, flod devices for bed/chair physician of any charmant in the score of the charge nunutrition/hydration of the charge nuntrition/hydration of the charge	I the resident had a BIM stated severe cognitive dent required extensive in for transfers and be ional limitations in rangification of the limitation of the	d d ge of d not y hths "" for er, 1 on. of the sue) ment vices am, on ely 9 that is skin of the ate elief notify	F 314				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/21/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
HODGEM	AN COUNTY HEALTH	I CENTER LTCU	809 BR	MLEY PO	BOX 367		
			JETMOR	RE, KS 678	54		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE		1
F 314	Continued From pag	e 16		F 314			
F 314	assessment) revealed unstageable pressure that measured 4 cm thad a stage 2 pressure measured 3 cm by 4 wound care treatment Culture of the coccyx Escherichia coli (gran lower intestine) treate 3/18/13. Treatment of day Safegel (type of dressing change. On center included reposas needed from side day for 20 minutes fo splint to the left foot as	d the resident had an e ulcer on his/her left he by 2.5 cm. The residen are ulcer on the coccyx to cm and currently receive tat a wound care center.	at also that yed er. Ind in) on vice a moist are and is a				
	revision date of 4/8/1 the resident to reposi needed to promote or on pillows while in be for pressure relief. The staff to apply skin reprocessing the acceptance of wrinkles, and assessment on first burning care plan included and 5/9/13. Interventions related wound assessments Resident #25's 2/7/13 included an order for bilateral feet. Further frequent changes to worm on pillows.	path day of the week. The luded treatment change 1/13, 2/28/13, 4/11/13, The care plan lacked to the expectations for and measurements. 3 admission physician of a dressing change daily physician's orders incle	as neels tress ted and and ne es on				

	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/21/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
HODGEM	AN COUNTY HEALTH	I CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE COMPL	ETION
F 314	3/19/13, 3/28/13, 4/1 5/9/13. Resident #25's 2/15/7 Braden Scale (tool us risk) scores revealed indicated moderate ridevelopment. An "Admission Nursin 2/7/13 revealed resid right forearm, left elbarea on the left and riassessment also ider the right heel and the section titled "Special change to heel daily, description or measurement and the section titled "Special change to heel daily. Tool" completed by light resident #25 from 2/1 completed weekly sk assessment tool had areas of concern, and dry sarea for comments. Resident #25's 2/7/13 stated the resident has with a daily dressing note lacked identification.	1/13, 4/25/13, 5/6/13, and 1/3, 3/17/13, and 5/3/13 sed to predict pressure a score of 18 which lisk for pressure ulcer and Assessment" dated lent #25 had scabs to thow and identified a "redight buttock. The ntified areas of concern edge of the right foot. I Treatment" stated, dreatments of the areas of cks and the right heel. Is "Nurses Skin Assessment lacked rements of the areas of cks and the right heel. Is "Nurses Skin Assessment forms. The abody outline to identified a body outline to identified and the right heel. The form included as, open lesions, blisters skin. The form included Review of resident #25' dmission revealed no essure ulcers that were in to the facility, a period and a blister to the left hee change. The admission tition and measurements buttocks identified on the state of the state of the left heechange. The admission tition and measurements buttocks identified on the state of the state of the left heechange. The admission tition and measurements buttocks identified on the state of the left heechange.	ulcer ne " on A essing d f ment f led The fy s, d an es	F 314			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER AND PLAN OF CORRECTION IDENTIFICATION NUMBER			1, ,	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
	17E627 B. WING 05/21/2013		05/21/2013				
NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
PRÉFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
the following: * 2/9/13 at 1:00 p.m. blister, intact, soft dar approximately 9 cm w * 2/24/13 9:00 a.m. buttock. Cleansed an Will continue to monit areas on the buttocks assessment dated 2/7 record lacked docume assessment with the fassessment of the are 17 days following adn * 2/26/13 Dressing to hs (hour of sleep). Cl redressedwound be side by side 1 cm by 2 (first documentation of after discovery of wou 2/24/13) * 3/6/13 at 9:15 a.m. 4 cm by 4.5 cmSac dark brownish in color cmfoul odor noted, back and showed head (Escherichia coli). Att (According to the reconstruction of the color color at a wound to the color c	Dressing change to left k red, measured vide and 4 cm high. Open area found on right applied Maxorb/Exuctor. (The resident had right on the admission nurs 7/13. Review of the clirentation of further first documentation of area on 2/24/13, a period nission) or right buttock coming of leansed and led dark pink with 2 area 2.5 cm and .5 cm by 1.5 of measurements of world available of the left heel wound measured and measured 3 cm by preliminary wound cultary growth of E. Colitempted to notify physicord, the resident began care center on 3/11/13 m. Left heel measurements on coccyx measurements on coccyx measurements. Heel remains 4 cm b	ght derm. red sing nical an l of off at as 5 cm. und ured s by 4 liture cian. B) eents ed by 2.5 in with eliminating with a	F 314				

17E627 B. WING 05/21/2013		EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURY COMPLETE	
		17E62	17E627 B. WING 05/21/2013		/2013		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	NAME OF PROVIDER	ER OR SUPPLIER	STREET ADDRE	ESS, CITY, STA	ATE, ZIP CODE		
HODGEMAN COUNTY HEALTH CENTER LTCU 809 BRAMLEY PO BOX 367 JETMORE, KS 67854							
PREFIX (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD BE	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETION DATE
F 314 * 4/23/13 at 11:50 p.m. Dressing change to coccyx area measured 4 cm in diameter with 1 cm depth. (No documentation of measurements of the area on the coccyx for a period of 21 days) * 4/29/13 at 10 p.m. Dressing on, wound vac dry and intact. Observed an 8 cm by 6 cm dark purple area on resident's right greater trochanter are, warm and painful to touch. * 5/9/13 at 3:15 p.m. Resident returned from acute care wound vac change, small open area found on right hip measured .7 cm by 1 cm. Wound cleansed and Safegelvaseline gauze dressings applied. * 5/12/13 at 10:00 a.m. Left heel measured 4 cm x 4.5 cm and .7 cm by 1 cm bruised area on right hip with open slit in center. (According to wound care center notes, the resident had a debridement of the heel wound on 5/6/13. Review of the record lacked documentation of the heel wound measurements from 3/23/13 until 5/12/13, a period of 50 days) Upon request, the facility obtained wound documentation from the acute care side of the facility where the resident received wound vac dressing changes. According to those records, staff assessment of the wound revealed: * 5/9/13 Stage 3 wound to coccyx with deep tissue/hecrosis with measurements of 3 cm length, 1.8 cm width, and 1.5 cm depth with tunneling 1.5 - 2 cm. * 5/13/13 Coccyx Stage 4 with loss of skin with extensive destruction, measured 3 cm width and 1.3 cm depth with 2.7 cm tunneling. Stage 2 superficial skin break with redness on left buttock with no measurement recorded. During an observation on 5/9/13 at 1:40 p.m., licensed nurse S wheeled resident #25 to the hospital for a dressing change to the wound on	* 4/2: coccy cm de of the * 4/2! and ir purple are, w * 5/9, acute found Woun dress * 5/1: x 4.5 hip wi care of debrid Revie heel w 5/12/* Upon docur facility dress staff a * 5/9, tissue length tunne * 5/1: exten 1.3 cr super with n During licens	depth. (No documentation of measured the area on the coccyx for a period of 21 d/29/13 at 10 p.m. Dressing on, wound vide intact. Observed an 8 cm by 6 cm dar ple area on resident's right greater trock, warm and painful to touch. G/9/13 at 3:15 p.m. Resident returned from the care wound vac change, small open and on right hip measured .7 cm by 1 cm ound cleansed and Safegel/vaseline gaussings applied. G/12/13 at 10:00 a.m. Left heel measured .5 cm and .7 cm by 1 cm bruised area of with open slit in center. (According to we center notes, the resident had a pridement of the heel wound on 5/6/13. Wiew of the record lacked documentation of the wound measurements from 3/23/13 unit 2/13, a period of 50 days) on request, the facility obtained wound cumentation from the acute care side of ility where the resident received wound resing changes. According to those record fassessment of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the wound revealed: G/9/13 Stage 3 wound to coccyx with decing the complex of the com	ith 1 iments days) ac dry k nanter imarea i. ize d 4 cm n right vound in of the ntil the vac ords, ep n n with h and 2 outtock m., he	F 314			

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	CLIA		LE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/21/2		
	OVIDER OR SUPPLIER			RESS, CITY, STA				
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	the resident's coccyx. performed a dressing wound which had a w measurements on the cm (centimeter) deep The wound measured wide. Another area or cm in length and 6.2 cricular area in center area measuring 0.7 cricular area in center dispressive Ulcer Recorveekly with dressing physician/physician erwounds, pressure ulcrodiagnoses. During an interview or care staff L stated the assistants) completed resident's bath and write anything like skin teal. During an interview or administrative nurse wound on resident #2 (5/3/13) and the physical Monday (5/6/13). He was not open when file. An interview on 5/10/administrative nurse wound assessments in the currently document produced assessments are currently document produc	Licensed hospital nurse change to the coccyx wound vac Wound exports and 1.8 with a 2 cm of tunneling 3 cm in length and 1.8 with the right hip measure cm wide with dark purpler with an open superficient by 1 cm in the center nurse T confirmed the lew and also stated the proved. 2/4/11 Wound Protocol aff to initiate Weekly and on admission and up changesFax extender, inform of new lers and have them con a 5/15/13 at 9:48 a.m. of a CNAs (certified nurse of bath sheets during the sill notify the nurse if the rise or bruises. In 5/9/13 at 3:12 p.m., A stated they discovered the further stated they are discovered on 5/3/13 at discovered on 5/3/13 at discovered on 5/3/13	ed 1.5 ig. 3 cm ed 7.7 ile al r of area area date firm direct ey see d the on area 3.	F 314				

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR I OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR I COMPLETE						
		17E627		B. WING		- 05/21/2013	
	OVIDER OR SUPPLIER			RESS, CITY, STA			
JET				AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	on-going assessment A further stated that r wound care clinic wee to call the wound care measurements. During an interview of administrative nurse of was made of the reside admission to the facility and him/herself. At the resident had a red ow with a "sheering" appinurse A stated that all had the appearance of He/she also confirme on the right heel prior. The facility failed to econsistent, ongoing not measurements of exist heel and coccyx, in one The facility failed to he consistent monitoring wounds. 483.25(h) FREE OF AHAZARDS/SUPERVITHE facility must ensure environment remains as is possible; and ear adequate supervision prevent accidents.	esident #25 went to the ekly and he/she would be center for their n 5/15/13 at 7:54 a.m., A stated that an assession that the hospital pricity by administrative nume time of admission that area above the coccearance. Administrative rout a week later the anof a deep tissue injury. It to admission. Insure resident had a bling to admission. Insure resident #25 recurring assessments are sting pressure ulcers or order to promote healing ave a system in place to and measurements of ACCIDENT SION/DEVICES Inter that the resident has ach resident receives and assistance devices and assistance devices and metas evidenced to the existence of accident has ach resident receives and assistance devices and assistance devices and the existence of accident has ach resident receives and assistance devices and assistance devices and the existence of accident has ach resident receives and assistance devices and assistance devices and the existence of accident has ach resident receives and assistance devices and assistance devices and the existence of the existence of the existence of accident has ach resident receives and assistance devices are accident has a contract the existence of the	e have sment or to urse R e cyx re rea sister eived and not the g. to for	F 314			
	The facility reported a residents identified at	a census of 21 with 5 cognitively impaired a	nd				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SU COMPLE	
		17E627		B. WING	 	05/21/2	
NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALTH CENTER LTCU				ESS, CITY, STA MLEY PO RE, KS 678	BOX 367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE) CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 323	independently mobile for accidents. Based on observation review the facility fails environment remaine hazards for 5 cognitiv mobile residents whe hazardous chemicals residents. The facility residents sampled for adequate supervision (Resident #10) Findings included: - Observation on 5/8/housekeeping closet and contained the foll * Betco cide-bet disin "Keep out of reach of skin irritation. Do not clothing. Harmful if sy * Betco ph7q in a spra According to www.be swallowed, causes ey * Dispatch disinfectan labeled avoid contact may cause stomach u *Comet cleaner with be "keep out of reach of swallowed. On 5/8/13 at 8:35 a.m opened housekeeping	and 3 residents reviewed, interview and record ed to ensure the resider of free of accidents and rely impaired, independ in staff stored potentially in an area accessible to also failed to ensure 1 raccidents received to prevent accidents. If a at 8:30 a.m. revealed door marked 220 unlock owing hazardous chemologically also failed to ensure 1 raccidents received to prevent accidents. If a at 8:30 a.m. revealed children, causes eye and get in eyes or on skin of wallowed. If a yes or on skin of wallowed, and skin irritation. In the with bleach, 3 full both with eyes, skin and clouds with eyes, skin and clouds with eyes, skin and clouds to consider the provident of the children, harmful if the consideration of the staff when not in use.	ently y to of 3 ed the eked nicals: and or ful if tles, othing, d	F 323			

NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALTH CENTER LTCU STREET ADDRESS, CITY, STATE, ZIP CODE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	PLE CONSTRUCTION	(X3) DATE SUR COMPLETI	
HODGEMAN COUNTY HEALTH CENTER LTCU (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 Continued From page 23 maintenance staff E confirmed that all housekeeping closet doors should remained locked and inaccessible to the residents. During an interview on 5/15/13 at 4:00 p.m., administrative staff A revealed the facility had 5 residents with cognitive impairment and independently mobile. The facility failed to ensure the resident environment remained as free of accident hazards as possible for 5 cognitively impaired, independently mobile residents when staff failed to lock the housekeeping closet which contained potentially hazardous chemicals. - Resident # 10's, 4/10/13 Annual MDS (minimum data set) revealed a BIMS (brief interview for mental status) score of 4 which indicated severely impaired cognitive skills. The assessment also revealed the resident required limited assistance of 1 staff for transfers and walking in room and used a walker and wheelchair for mobility. The assessment further revealed resident #10 had an upper extremity			17E627		B. WING			
CALL D PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION TAG			CENTER LTCU					
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 323 (Continued From page 23 maintenance staff E confirmed that all housekeeping closet doors should remained locked and inaccessible to the residents. During an interview on 5/15/13 at 4:00 p.m., administrative staff A revealed the facility had 5 residents with cognitive impairment and independently mobile. The facility failed to ensure the resident environment remained as free of accident hazards as possible for 5 cognitively impaired, independently mobile residents when staff failed to lock the housekeeping closet which contained potentially hazardous chemicals. - Resident # 10's, 4/10/13 Annual MDS (minimum data set) revealed a BIMS (brief interview for mental status) score of 4 which indicated severely impaired cognitive skills. The assessment also revealed the resident required limited assistance of 1 staff for transfers and walking in room and used a walker and wheelchair for mobility. The assessment further revealed resident #10 had an upper extremity				JETMOR	RE, KS 678	54		
maintenance staff E confirmed that all housekeeping closet doors should remained locked and inaccessible to the residents. During an interview on 5/15/13 at 4:00 p.m., administrative staff A revealed the facility had 5 residents with cognitive impairment and independently mobile. The facility failed to ensure the resident environment remained as free of accident hazards as possible for 5 cognitively impaired, independently mobile residents when staff failed to lock the housekeeping closet which contained potentially hazardous chemicals. - Resident # 10's, 4/10/13 Annual MDS (minimum data set) revealed a BIMS (brief interview for mental status) score of 4 which indicated severely impaired cognitive skills. The assessment also revealed the resident required limited assistance of 1 staff for transfers and walking in room and used a walker and wheelchair for mobility. The assessment further revealed resident #10 had an upper extremity	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
balance moving from a seated to standing position, walking, turning around, and was not steady with surface to surface transfer. According to the assessment the resident had no falls since the prior assessment. Resident #10's CAA (care area assessment) dated 4/10/13, triggered for history of falls with preventative fall measures in place. The 4/11/13 nursing care plan for resident #10 alerted staff that resident #10 had a history of falls resulting in fracture, for staff to evaluate falls, keep bed at lowest position, listen for the	F 323	maintenance staff E of housekeeping closet locked and inaccessil. During an interview of administrative staff A residents with cognitive independently mobile. The facility failed to environment remaine hazards as possible findependently mobile to lock the housekeep potentially hazardous. Resident # 10's, 4/2 (minimum data set) resinterview for mental sindicated severely implied assistance of walking in room and wheelchair for mobility revealed resident #10 range of motion imparts balance moving from position, walking, turns steady with surface to According to the asset falls since the prior as Resident #10's CAA (dated 4/10/13, trigger preventative fall measured staff that resident staff that r	confirmed that all doors should remained ble to the residents. In 5/15/13 at 4:00 p.m., revealed the facility have impairment and experience of accident for 5 cognitively impaired residents when staff facing closet which contains chemicals. In MDS evealed a BIMS (brief status) score of 4 which paired cognitive skills. Ealed the resident requiral staff for transfers and used a walker and many. The assessment fur of had an upper extremit imment and had difficulting a seated to standing hing around, and was not surface transfer. Easment the resident has seessment. In Market Ma	od 5 ed, ailed ailed ined The ired I ther ty y with ot ad no) ith	F 323			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/21/2		
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
				AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 323	personal alarms on the promptly. The care puse a scoop mattress. Resident #10 's fall a and 4/6/13 identified to "for falls. Resident #10's trans revealed that the resident weight, did not have the needed to support we assessment further resident had conclustory of falls. Review of the Nurses Documentation sheet * 3/9/12 at 11:55 p.m. the clinical record reveasessment of the fall implementation of appstrategies after the fall * 3/24/12 non-injury frecord revealed no extending the fall for causative fappropriate fall preves to prevent additional * 4/3/12 at 11:00 p.m. the clinical record reveasessment of the fall implementation of appstrategies after the fall record reveasessment of the fall implementation of appstrategies after the fall record reveasessment of the fall implementation of appstrategies after the fall * 2/27/13 at 10:00 p.m. facility added a person	ne bed and chair and ar lan also directed the state with a sensor mat. Assessment dated 1/6/1 the resident as a "high fer assessment dated 4 dent required only particifer, was unable to bear the upper body strength eight during transfer. The evealed the resident was to cooperative or unable the assessment revealed ditions of dementia and as Notes and Fall is revealed the following or non-injury fall. Reviewelled no evidence of a for causative factors of propriate fall preventional fall. Review of the clinic vidence of assessment factors of implementation strategies after the falls. It non-injury fall. Reviewelled no evidence of a for causative factors of implementation tion strategies after the falls. It non-injury fall. Reviewelled no evidence of a for causative factors of propriate fall preventional falls. It non-injury fall. Reviewelled no evidence of a for causative factors of propriate fall preventional falls. It non-injury fall. The nal body alarm after the causative factors of propriate fall preventional falls. It non-injury fall. Reviewelled the falls.	aff to 3 n risk 4/4/13 dal r n he as to d that g: w of or falls. cal of on or e fall ew of falls. ew of	F 323				

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		17E627		B. WING		05/2	21/2013
	OVIDER OR SUPPLIER AN COUNTY HEALTH	1 CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367	•	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 323	assessment of the falimplementation of apstrategies after the fali	all for causative factors of appropriate fall prevention all to prevent additional fall. Reviewedled no evidence of all for causative factors of appropriate fall preventional to prevent additional fall to prevent additional fall for causative factors of all for causative fall preventional fall to prevent additional fall for causative fall fall for causative fall fall for causative fall fall fall fall fall fall fall fal	of falls. ew of falls. ew of falls. or of falls. or of falls. or of the falls. f the falls. ed the fall of to the fall of to the fall of to the fall of the fall o	F 323			

(X2) MULTIPLE CONSTRUCTION

	` '		` '		(X3) DATE SURVEY COMPLETED	
	17E627		B. WING	 	05/21/2	2013
OVIDER OR SUPPLIER		STREET ADDRI	ESS, CITY, STA	TE, ZIP CODE		
AN COUNTY HEALT	H CENTER LTCU					
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26		ULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETION DATE
Continued From pa	ge 26		F 323			
direct care staff K re required the use of a his/her wheelchair a while in bed. Staff fi is transferred the result assistance of two streported that Reside happened when he/him/herself from one. During an interview licensed staff C reve when he/she experieused a personal bod when in the wheelch C reported that reside the doctor ordered a chronic UTI (urinary staff C stated staff c ensure proper functistated the facility falresident, if the resident to be taken to the erobtains vital signs and The facility failed to for causative factors prevention strategie the interventions and to prevent future fall 483.25(j) SUFFICIE HYDRATION The facility must pro	evealed that Resident #1 a personal body alarm of a personal body alarm of and recliner and a bed alsurther stated that resides sident with a gait belt an aff. Direct care staff K for the foliation of the folia	on arm arm at #10 d arm at #10 d arm at #10 d arther at staff at s	F 327			
and health.						
	SUMMARY: (EACH DEFICIENT REGULATORY OF THE REGUL	OVIDER OR SUPPLIER AN COUNTY HEALTH CENTER LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FREGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 During an interview on 5/15/13 at 10:05 a.m direct care staff K revealed that Resident #1 required the use of a personal body alarm on his/her wheelchair and recliner and a bed all while in bed. Staff further stated that reside is transferred the resident with a gait belt an assistance of two staff. Direct care staff K for reported that Resident #10's falls normally happened when he/she tried to transfer him/herself from one place to another. During an interview on 5/15/13 at 11:20 a.m licensed staff C revealed that resident #10 for when he/she experienced delusions and that used a personal body alarm on resident #10 when in the wheelchair or recliner. Licenses C reported that resident #10 had less falls sithe doctor ordered a long term antibiotic for chronic UTI (urinary tract infection). License staff C stated staff checked the alarms daily ensure proper functioning. License staff C fits atted the facility fall protocol was to access resident, if the resident is in a lot of pain the to be taken to the emergency room, the staff obtains vital signs and looks in to cause of fit of causative factors, implement new fall prevention strategies, monitor for effectivency the interventions and modify them as necess to prevent future falls. 483.25(j) SUFFICIENT FLUID TO MAINTAll HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydroside.	AN COUNTY HEALTH CENTER LTCU SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 During an interview on 5/15/13 at 10:05 a.m., direct care staff K revealed that Resident #10 required the use of a personal body alarm on his/her wheelchair and recliner and a bed alarm while in bed. Staff further stated that resident #10 is transferred the resident with a gait belt and assistance of two staff. Direct care staff K further reported that Resident #10's falls normally happened when he/she tried to transfer him/herself from one place to another. During an interview on 5/15/13 at 11:20 a.m., licensed staff C revealed that resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 when in the wheelchair or recliner. Licensed staff C reported that resident #10 had less falls since the doctor ordered a long term antibiotic for chronic UTI (urinary tract infection). Licensed staff C stated staff checked the alarms daily to ensure proper functioning. License staff C further stated the facility fall protocol was to access the resident, if the resident is in a lot of pain they are to be taken to the emergency room, the staff also obtains vital signs and looks in to cause of fall. The facility failed to evaluate resident #10's falls for causative factors, implement new fall prevention strategies, monitor for effectiveness of the interventions and modify them as necessary to prevent future falls. 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration	TRECTION TRECT TRECTION TRECTION NUMBER: A. BUILDING	TREET ADDRESS, CITY, STATE, ZIP CODE 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8. WING STREET ADDRESS, CITY, STATE, ZIP CODE 8. WING STATEMENT OF DEFICIENCIES (RACH DISPICIPIENT WINST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 26 During an interview on 5/15/13 at 10:05 a.m., direct care staff K revealed that Resident #10 required the use of a personal body alarm on his/her wheelchair and recliner and a bed alarm while in bed. Staff further stated that resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on nesident #10's falls normally happened when he/she tried to transfer him/herself from one place to another. During an interview on 5/15/13 at 11:20 a.m., licensed staff C revealed that resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 fell when he/she experienced delusions and that staff used a personal body alarm on resident #10 fell when he/she experienced delusions and that staff used by the personal body alarm on resident #10 fell when he/she experienced delusions and that staff used by the personal body alarm on resident #10 fell when he/she experienced delusions and that staff used by the personal body alarm on the personal b	TORNITOR OF THE PROPERTY OF TH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 327	The facility had a cen residents selected for included review of hydrological particles and a selected for included review of hydrological particles and a syste sampled residents remaintain proper hydrological propers hydrological propers hydrological propers and a syste sampled residents remaintain proper hydrological propers hydrological propers and a significant propers and a system of the system of the selection or the selection of the system of the system of the selection of the system of the selection of the selection of the system of t	al record included physication and health. (Residual rather than true surroundings). S (Minimum Data Set) with long and short terroderately impaired decidependence on staff foily living) including eating, and the presence of the procure own fluids on the procure own fluids of	ch 16 cility of 1 clent dent m ision or all ng, a om of cof e o the cy ren n	F 327				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		1 1	E CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E627		B. WING		05/2	1/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HODGEM	AN COUNTY HEALT	H CENTER LTCU		MLEY PO			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			ULD BE	(X5) COMPLETION DATE
F 327	[ne/she] will general Resident #4's care pinterventions on 12/the resident's "poter "goal" for dehydratic maintained as evide [temperatures] over plan lacked informatemperatures relate plan also directed siroom at all times, of monitor vital signs with monitor for signs/sy notify the physician occurred. The care interventions related needs and how staff offered the resident "Hydration Assessmand 12/8/12 describinsk" for dehydration A "Medical Nutrition progress note dated #4's daily fluid need centimeters) and aw of fluid, a deficit of 60 A Nutritional Assess calculated resident cc's, with an averagifluid, a deficit of 497 Review of December February 2013 Fluid recorded identical in days during each missing protest in the resident in the side of the si	plan noted staff review of 27/12. The care plan no intial for dehydration". The on included, "Hydration wenced by normal body teather next 90 days." The otion as to how body do dehydration. The cataff to keep fresh water if fer liquids with all interactive early and as needed, in motion as to how body do to dehydration. The cataff to keep fresh water if fer liquids with all interactive early and as needed, in motion and family if dehydration plan lacked individualized to resident #4's specific for planned to ensure staff that amount of fluids data ments" completed on 9/7/2 ded resident #4 as "mode". all Therapy" Quarterly defended as "mode". all Therapy" Quarterly defended as "mode". sas 1420 cc's (cubic rerage daily intake of 762 designed as as edaily intake of 526 cc's daily intak	of ted ted will be mps care are n the ctions, and n ed c fluid filly. 1/12 erate dent 2 cc's 18/12 1023 5 of nd d staff of the	F 327			

	OF DEFICIENCIES F CORRECTION						
		17E627		B. WING		05/2	1/2013
	OVIDER OR SUPPLIER	05VT5D T0V		RESS, CITY, STA			
HODGEM	AN COUNTY HEALTH	CENTER LICU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 327	Continued From page	e 29		F 327			
	"Food Intake Records documented resident meals the entire montrecords, the resident 15% of one meal, 25% meals and 75% of 8 r consumed less than 193 meals during the normal part of the properties of the glasses of the resident's food and containers. Staff M consume all of the food resident did not receive fluids offered even the were empty at the end to table and not containers and if there end of the meal. If he that means the resident means the resident resident means the resident that means the resident means the resident that means the resident mea	"for January 2013 #4's food intake for 93 th. According to those took only 10% of one m of 12 meals, 50% of neals. The resident 100% of his/her meal 3' nonth of January 2013. In 5/14/13 at 10:50 a.m. onfirmed resident #4 nce with eating and drin resident #4 took his/he in staff mixed them toge proved of staff doing the he always poured the es/cups containing fluid d then fed from the foo onfirmed that process le ut, if the resident didn't be d mixed with the fluid, we the entire quantity of ough the fluid container d of the meal. In 5/14/13 at 11:00 a.m. med dietary staff have t ding fluid intakes after Staff F, he/she goes fro	15 7 of nking ether at. s into d eft the f rs he m he uss fluids				
	During an interview of Administrative Nurse care plan lacked a me	n 5/14/13 at 10:00 a.m. A confirmed resident # eaningful, measurable of erventions related to the	., 4's goal				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME					
		17E627		B. WING		05	5/21/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STAT	E, ZIP CODE		
HODGEM	AN COUNTY HEAL	TH CENTER LTCU		AMLEY PO E RE, KS 6785			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY I REGULATORY OR LSC IDENTIFYING INFORMA		FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 327	ensure the resider daily. Administrative poured resident #4 alter the consister method improved poured the containers of fempty even if the the food/fluid mixture assume the resider review of fluid intail. January 2013, Nur recorded at each in contained in the gresident and not not consumed by resident and not not not not not not review regular basis to deadequate to meet a resident with a horizontained in the famintenance" polical appropriate preventing propriate pr	fluid needs and methods not received adequate fluid we Nurse A also confirmed 4's fluids into his/her food acy of the food because the the resident's intake. Once its of the fluid containers it food, the fluid containers it food, the fluid containers were sident did not consume ure, and dietary staff mighent drank all of the fluids. It is the records for the montherse A confirmed the amounts lasses/cups offered to the recessarily the amounts of dent #4. Nurse A also report the fluid intake sheets or extermine if a resident's into their needs, even in the constitution of dehydration such acility's "Hydration/Fluid cy, staff should develop a mattive plan of care and ration plan based on onses, outcomes and the	d staff to d staff to eat to eat ee staff into ee staff into Upon of unts ef fluid orted ake is ease of ease or as n to os staff of ee ff intly in a	F 327			
F 329	483.25(I) DRUG F	REGIMEN IS ERFE FROM	1	F 329			

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	•	
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 329	Continued From page UNNECESSARY DRIVERS (SARY DRIVERS) and resident's drug unnecessary drugs. A drug when used in extending the duplicate therapy); or without adequate more indications for its use; adverse consequences should be reduced or combinations of the resident, the facility may be a diagnosed and door resident, the facility may be a diagnosed and door record; and residents drugs receive gradual behavioral intervention contraindicated, in an drugs. This Requirement is The facility reported a residents sampled for Based on observation review, the facility fail sampled residents diagnosed to the diagnosed and door record; and residents drugs receive gradual behavioral intervention contraindicated, in an drugs.	regimen must be free fran unnecessary drug is cessive dose (including for excessive duration; nitoring; or without adea, or in the presence of es which indicate the dodiscontinued; or any easons above. The sense of essence of esse	om s any d or quate ose ints not ition ese	F 329			
	26, and 7.	ents # 10, 9, 17, 16, 6, 2	z, zz,				

4PWM11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		17E627		B. WING		05/2	1/2013
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HODGEM	AN COUNTY HEALT	TH CENTER LTCU		MLEY PO I RE, KS 6785			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 329	Findings included: Resident # 10's A set) dated 4/10/13 is severe cognitive im The assessment fur received 7 days of anti-depressant me assessment period Resident #10's CAA summary dated 4/1 loss/ dementia due behavioral sympton behaviors, mood/ b becoming agitated summary for psych resident developed use of Remeron (ar and Xanax (an antisummary further reconsultant pharmac psychotropic mediciant with the consultant pharmac psychotropic mediciant for increasi and to provide reas anxiety. Resident #10's 5/2 revealed a renewed * Remeron, an anti-(milligrams) every consultant and to provide reas anxiety.	annual MDS (minimum darevealed the resident had pairment and mild deprenther revealed the reside anti-anxiety and dications during the dications during the dications during the dispersion of the diagnosis of dementia with selection and combative. The CA cotropic drug use identifies adverse reactions due to anti-depressant medical anxiety medication). The evealed the physician and coist monitored the use of actions. Traing care plan dated 3/8 crease the resident 's could be provided and depression of an anxiety and depression of the dispersion of	ssion. nt) ve a, some ent A d the othe ation) e //13 oport, on	F 329			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	behavior monitoring for monitored for a variet resident #10. Review forms lacked evidence behaviors they hoped use of Remeron and resident #10 for the properties behaviors. During an observation Resident #10 sat at the not exhibit any behave. During an interview of Administrative Nursing utilized a "mood and be residents regardless of received to document verified the facility lactoresident #10's target behaviore. The facility failed to enot receive unnecess lack of evidence of monitoring with the resident #9's 1/5/1 data set) revealed the impaired cognition and revealed resident #9 anti-psychotic, anti-armedications during the Resident #9's CAA (controlled the second resident #9's	orm on which staff y of behaviors not spec y of the behavior monito e staff identified the tar I to control/improve with Xanax, and then monito resence/ absence of the n on 5/14/13 at 4:00 p.r. ne dining room table, an ioral symptoms or anxi- on 5/15/13 at 8:06 a.m. g Staff A reported the f behavior" form for all of type of medication t unusual behaviors. Sicked evidence of monito behaviors/symptoms w eron and Xanax. Insure that Resident # 1 ary medications related onitoring target behavior and Remeron and Xanax 3 Annual MDS (minimus e resident had severely d no depression. It furt received 7 days of existy, and anti- depres	oring get in the ored ose m., ind did ety. facility taff A oring hile 10 did d to ors in ther sant	F 329				
	cognitive loss/ demen	itia, psychosocial wellb	eing,					

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	behavioral symptoms pain. The summary stated telusions, particularly and children. The surresident becomes any restless, anxious and stated resident #9 wadrug related side efferement and Xanax. Resident #9 's nursing directed staff to assess changes, monitor for medications and to muse of psychotropic directed staff to provide supervisor for resident was endeathed. Resident #9's clinical targeted behaviors for Remeron and Buspar physician order sheet for: * Xanax, (an anti-anximilligram) at noon and the supervisor for sheet for: * Xanax, (an anti-degree times and supparticular through and supparticular th	, psychotropic drug use tated resident #9 had involving his/her parer mmary further stated the gry with staff, becomes tearful. The summary is at high risk for develocts due to the use of In ag care plan dated 3/12 is and monitor behavior over sedation of conitor for side effects or ugs. The care plan funde frequent and consist in #9. Trecord lacked monitoring the use of Xanax, Involved in the use of Xanax, Involved in the use of Xanax included renewed order included renewed order included renewed order included renewed order of unspecified psychostepressant medication) in the evening chotic medication) in the evening of unspecified psychostepressant medication) in the evening of unspecified psychostepressant medication) is the record included a general part of the part of the part of the present medication) is the record included a general part of the part	also oping vega, /13 r ff the rther tent mg for ega, ers mg g sis. 30 5 mg eric cific to ing get in the	F 329				

4PWM11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		' '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
	OVIDER OR SUPPLIER			RESS, CITY, STA	•			
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 329	then monitored resided absence of those specified and observation direct care staff L who room. Staff L offered no behavioral symptom During an interview on Licensed staff C configuration wandered in the hallwadusive towards staff required a wander guild hallways. Licensed staff required a wander guild hallways. During an interview of Administrative Nursin utilized a "mood and it residents regardless of received to document verified the facility lace resident #9's target by he/she received Xana Buspar. The facility failed to enot receive unnecess	ent #9 for the presence/ ecific behaviors. In on 5/14/13 at 10:50 a eeled resident # 9 to his water to the resident, was or agitation noted. In 5/15/13 at 11:15 a.m., irmed that resident # 9 ways, could become ver generally anxious and ard due to pacing in the taff C further revealed to same behavior sheet was that staff can put in a dents being monitored of the tags of the property of the following form for all of type of medication to unusual behaviors. So sked evidence of monitor that ary medications when so monitor for target behavior of target and target per service of the property of the propert	.m., s/her with ., rbally le that which for facility taff A pring ile nd	F 329				
		arterly MDS (minimum on the desired the residentified the residentified the resident the residen						

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 329	with intact cognition, in hallucination, and antianti-depressant use of Resident #17's CAA (dated 5/23/13 revealed pscyhotropic medicated staff to monitiand psychological characteristic effectiveness of Seron medication) and Celemedication) and Celemedication.) Resident #17's 5/1/13 renewed orders for: *Seroquel XR 50 mg pschosis with behavior * Celexa 10 mg daily Resident #17's clinical behavior monitoring for a variet resident #17. Review forms lacked evidence target behaviors they with the sue of Seroq monitor resident #17 of thsoe specific behavioral symptom During an observation resident #17 sat in his Pepsi. The resident observation resident #17 sat in his Pepsi. The resident observation resident #17 sat in his Pepsi. The resident of behavioral symptom	no depressin, delirium of i-pyschotic and daily. (care area assessment) ed resident #17's use of ions. Ing care plan dated 5/4/1 tor for significant physiciange, recview and assequel (an anti-psychotic xa (an anit-depressant) as physcian's orders reveal (milligrams) daily for attended a general disturbances, for depressive disorder all record included a general disturbances of the behaviors no special of the behavior monitor that staff identified they hoped to control/improduel and Celexa, and the for the presence/abscelaviors. In on 5/8/13 at 8:25 a.m. sher room sipping on a did not exhibit any s. In 5/15/13 at 8:06 a.m., A reported the facility	f f f f f f f f f f f f f f f f f f f	F 329				

4PWM11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/	21/2013	
	ROVIDER OR SUPPLIER IAN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	residents regardless or received to document verified the facility lad resident #17's target he/she received Sero. The facility failed to enot receive uneccess the lack of evidence obehaviors while residence of behaviors while residence of the lack of evidence of evidence of the lack of evidence of the lack of evidence of evidence of evidence of the lack of evidence of evide	of type of medication to unusual behaviors. So wheel evidence of monitor behaviors/symptoms with quel and Celexa. Insure that resident #17 ary medications related of monitroing target enc received Seroquel with 3 Annual MDS (minimated cognition with no act cognition with no act cognition with no act and Rozarem. The aled that resident #16 of adverse reactions suggested to a series of monitor routinely. In a case of the property of the prope	oring hile did d to and mum r hilly e uch he vioral ioral ealed	F 329				

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALTH CENTER LTCU (X4) ID PREFIX TAG Continued From page 38 tablemates. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form for all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #16's target behaviors/symptoms while STREET ADDRESS, CITY, STATE, ZIP CODE 809 BRAMLEY PO BOX 367 JETMORE, KS 67854 D PROVIDER'S PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 329 Continued From page 38 TF 329 F 329 F 329 F 329			(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
HODGEMAN COUNTY HEALTH CENTER LTCU 809 BRAMLEY PO BOX 367 JETMORE, KS 67854 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 38 tablemates. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form forl all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #16's target behaviors/symptoms while			17E627		B. WING		05/2	21/2013
CX4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 38 tablemates. Tag Tag	NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 329 Continued From page 38 tablemates. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form forl all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #16's target behaviors/symptoms while	HODGEM	AN COUNTY HEALTH	I CENTER LTCU					
tablemates. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form forl all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #16's target behaviors/symptoms while	PRÉFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY F	ULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETION
he/she received Remeron and Celexa. The facility failed to ensure that resident #16 did not receive uneccessary medications related to the lack of evidence of monitroing target behaviors while residenc received Remeron and Celexa - Resdient #6's Quarterly MDS (minimum data set) dated 3/18/13 identified the resident with moderately impaired cognition, minimal depression, and no behaviors Resdient #6's 10/2/12 CAA (care area assessment) summary noted the residents use of psychotropic medications. REsident #6's nursing care plan dated 8/18/12 directed staff to monitor for significant physical and psychological changes, to reveiw and assess the effectivness of the drugs Trazadone and Lexapro. Resident #6's 5/1/13 physcians orders revealed a renewed order for: *Trazadone (an anti-depressant) 150 mg (milligrams) every night at bedtime. *Lexapro (an anti-depressant) 20 mg daily.	F 329	tablemates. During an interveiw of Administrative Nurse utilized a "mood and residents regardless received to document verified the facility lad resident #16's target he/she received Remarkshe received Remarkshe received Remarkshe received Remarkshe receive uneccess the lack of evidence of behaviors while residence of the lack of evidence of evidence of the lack of evidence of the lack of evidence of the lack of evidence of evidence of evidence of the lack of evidence	on 5/15/13 at 8:06 a.m., A reported the facility behavior" form forl all of type of medication at unusual behaviors. Socked evidence of monito behaviors/symptoms wheron and Celexa. The sary medications related of monitroing target lenc received Remeron and the resident with cognition, minimal behaviors,. CAA (care area ry noted the residents utions. Geare plan dated 8/18/itor for significant physicianges, to reveiw and as edrugs Trazadone and physicians orders reveal depressant) 150 mg ght at bedtime.	taff A bring chile b did d to and ata h	F 329			

(X2) MULTIPLE CONSTRUCTION

4PWM11

. ,		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/21	/2013
	OVIDER OR SUPPLIER AN COUNTY HEALTH	I CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 329	During an observation on 5/8/13 at 8:20 a.m., resident #6 sat in a wheelchair in the dining room and consumed morning meal and did not exhibit any behavioral sypmtoms. During an interveiw on 5/15/13 at 8:06 a.m., Administrative Nurse A reported the facility utilized a "mood and behavior" form forl all residents regardless of type of medication received to document unusual behaviors. Staff A verified the facility lacked evidence of monitoring resident #6's target behaviors/symptoms while he/she received Trazadone and Lexapro. The facility failed to ensure that resident #6 did not receive uneccessary medications related to the lack of evidence of monitroing target behaviors while residenc received Trazadone and Lexapro.		F 329				
	included diagnoses of untrue persistent beliperson although evid anxiety (a mental or echaracterized by appirrational fear) and defendings of sadness, very emptiness). Resident #2's 4/13/13 Data Set) Assessment impaired cognition, more of the persistent includes the same of the persistence of the	rehension, uncertainty a epression (abnormal acterized by exaggerate worthlessness and 3 Quarterly MDS (Minim nt reported moderately hild depression, and reported the resident c and antidepressant	n / a) with and				

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	, ,	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCII		RESS, CITY, STA				
HODGEW	AN COUNTY HEALTH	CENTER LICO		RE, KS 678				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 329	Continued From page 40			F 329				
F 329	Resident #2's 1/16/13 Assessment) summarexperienced delusion deceased spouse and find him/her. Resident #2's 1/16/13 Drug Use CAA summareceived an antidepreto little energy and post antipsychotic medical. Resident #2's care plainstructed staff to more effects and/or adversa Risperdal (an antipsy Remeron (an antidepression (milligrams) orally dai with anxiety with a star Remeron 15 mg orally depression with a star Resident #2's clinical behavior monitoring for monitored for a variet not specific to resider #2's behavior monitor that staff identified tar improve/control with the	Behavior CAA (Care Any reported the resident is related to stating his/lid parents being unable in Mood and Psychotropharies reported the residence in a petite and any state of the properties and the properties are the properties and the properties are the properties and the properties are properties are properties and the properties are properties are properties and the properties areal properties are properties and the properties are properties a	t her to	L 25A				
		acked monitoring of the those specific behavior						
	resident #2 ate all of l conversed pleasantly	n on 5/9/13 at 7:58 a.m his/her meal independe with staff, and made no lated to his/her family b	ently, o					

4PWM11

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	unable to find him/her During an interview of Administrative Nursing utilized the same "modocument unusual be regardless of type of verified the facility lad resident #2's target by he/she received Risport The facility failed to ereceive unnecessary adequate monitoring evidence of monitoring evidence of monitoring behaviors/symptoms Risperdal and Remerate - Resident #26's 5/7/included a diagnosis musculoskeletal pain, and severe sleep dist sudden overpowering (abnormal emotional exaggerated feelings and emptiness), and emotional reaction chapprehension, uncertainty Resident #26's 4/15/15 Status MDS (Minimur reported no cognition depression, and the rantipsychotic and ant the 7 observation day resident received no aduring the observation Resident #26's 4/25/15	n 5/15/13 at 8:06 a.m., g Staff A reported the food and behavior" form chaviors for all residents medication received. Sieked evidence of monitor ehaviors/symptoms while erdal or Remeron. Insure resident #2 did not medications related to as the facility lacked g target while the resident receiven. It is signed physician's confibromyalgia (condition, spasms, stiffness, fatigurbance), panic disorder fear), depression state characterized by of sadness, worthless anxiety (a mental or paracterized by ainty and irrational fear impairment, mild esident received interpretation.	to s Staff A S	F 329				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	1, ,	(X3) DATE SURVEY COMPLETED		
		17E627		B. WING		05	21/2013		
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BRA	DDRESS, CITY, STATE, ZIP CODE BRAMLEY PO BOX 367 IORE, KS 67854					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 329	the resident received medication) for panic antidepressant medic fibromyalgia pain, and antianxiety medication. Resident #26's care particles and/or ad the resident received. Clonazepam, and Resincluded interventions and emotional support and monitor the effect medications. Resident #26's 5/7/13 included renewed ord 2/15/13 for Abilify 2 m treat panic disorder a 60 mg orally twice a confibromyalgia, and Clothree times a day to the physician's orders incomplete and to changorally in the morning and evening. Resident #26's clinication and the morning for a variet not specific to resider #26's behavior monitor that staff identified tar improve/control with the Clonazepam, or Rem	Abilify (an antipsychoti attacks, Cymbalta(an ation) for depression and Clonazepam (an in) for anxiety. Abilify, Cymbalta, meron. The care plan is to allow the resident to the during times of distretiveness of pain Signed physician's orders with start dates of any (milligrams) orally dand fibromyalgia, Cymbaltay to treat depression mazepam 0.5 mg orally reat anxiety. The 5/8/13 cluded orders for Reme edication) 7.5 mg orally the Clonazepam to 0.5 mg and at noon and 1 mg in all record included a gelat record included a gelatic content of the content of t	nd ole while ime ss ders aily to alta and y as ron y at ng n the neric ere ent ence oed to oalta,	F 329					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	17E627		B. WING		05/	21/2013	
NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALTI	1 CENTER LTCU	809 BR	DRESS, CITY, STATE, ZIP CODE RAMLEY PO BOX 367 ORE, KS 67854				
PRÉFIX (EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
resident #26 ate all of and showed no outwood not show a	on on 5/9/13 at 8:13 a.m. of his/her meal independ and signs of distress. on 5/15/13 at 8:06 a.m., on Staff A reported the food and behavior" form ehaviors for all residents medication received. Socked evidence of monitor behaviors/symptoms wify, Cymbalta, Clonazep ensure resident #26 did medications related to a sthe facility lacked on the facility lacked my target while the resident receivates while the resident receivate on the facility lacked on the	facility to s Staff A pring thile pam, not ived pn. prders e mory,	F 329				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING	·	05/2	1/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329	1 5			F 329				
	and refused medications prior to admission to an acute psychiatric hospital on 9/26/12. The Delirium CAA reported the resident returned on 10/9/12 to the long term care facility with a diagnosis of delirium secondary to a urinary tract infection.							
	Resident #22's 10/17/12 ADL (Activities of Daily Living) CAA summary reported the resident experienced delusions, screamed out without the ability to articulate why, and accused staff of attempting to hurt him/her. The ADL CAA reported the resident refused to eat or drink at times.							
	Resident #22's 10/17/12 Behavioral CAA summary reported that staff identified no pattern of what caused the resident to display behaviors and the resident received Zyprexa (an antipsychotic medication), Trazadone (an antidepressant medication), and Lexapro (an antidepressant medication).		viors					
	effects and/or adverse resident received Lex Zyprexa. The care pl monitor for alterations document incidents o	aff to monitor potential are consequences while a apro, Trazadone, and an instructed staff to a in his/her mood and to the "mood and behaves tructed staff to monit	the o viors"					
	orders for Lexapro 20 with a start date of 12 orally at bedtime with additional 25 mg 1 ho with a start date of 12	s orders included renew mg (milligrams) orally 1/28/11, Trazadone 25 r an as needed order for our after the scheduled 1/4/12, and Zyprexa 5 m a start date of 2/8/13.	daily mg r an dose					

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

17E627 B. WING 05/21/20 ⁻	
NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALTH CENTER LTCU 809 BRAMLEY PO BOX 367 JETMORE, KS 67854	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX
Resident #22's clinical record included a generic behavior monitoring form on which staff monitored for a variety of behaviors which were not specific to resident #22. Review of resident #22's behavior monitoring forms lacked evidence that staff identified target behaviors they hoped to improve/control with the use of Lexapro, Trazadone, and Zyprexa, and then lacked monitoring of the presence/absence of those specific behaviors. During an observation on 5/8/13 at 8:18 a.m., resident #22' received assistance to eat his/her meal and ate the majority of his/her meal without difficulty or episodes of crying or screaming out. During an interview on 5/15/13 at 8:06 a.m., Administrative Nursing Staff A reported the facility utilized the same "mood and behavior" form to document unusual behaviors for all residents regardless of type of medication received. Staff A verified the facility lacked evidence of monitoring resident #22's target behaviors/symptoms while he/she received Lexapro, Trazadone, and Zyprexa. The facility failed to ensure resident #22 did not receive unnecessary medications related to adequate monitoring as the facility lacked evidence of monitoring target behaviors/symptoms while the resident #22's target behaviors/symptoms while the resident received Lexapro, Trazadone, and Zyprexa. - Resident #7's 5/7/13 signed physician's orders included a diagnosis of depression (progressive mental disorder characterized by failing memory, confusion). Resident #7's 4/10/13 Quarterly MDS (Minimum	Rebel monot #22 that import th

4PWM11

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 329	Data Set) Assessmer cognition, minimal de delusions. The MDS in displayed physical be rejected cares 1 to 3 period. The MDS repantipsychotic and ant the 7 observation day Resident #7's 8/7/12 (Care Area Assessmeresident received antistaff monitored for poadverse reactions. Resident #7's care plainstructed staff to ass provide quality listenine experienced crying epinstructed staff to moneffects and adverse cresident received antistructed staff to moneffects and adverse or resident received antimates and adverse or resident received antimates. Resident #7's signed renewed orders for the medications: * Celexa 20 mg (millistant date of 3/4/10 * Wellbutrin XL 75 m date of 2/8/13 * Remeron 7.5 mg or date of 5/8/13 Resident #7's clinical behavior monitoring for monitored for a variety not specific to resider #7's behavior monitorioritoritoric for specific to resider #7's behavior monitoritoritoritoritoritoric for specific to resider #7's behavior monitoritoritoritoritoritoritoritoritoritor	nt reported severely impression, and experient pression, and experient pression, and experient preported the resident haviors toward others a days during the observation of the resident receidepressant medication and the second depressant medication are antidepressant medication are antidepressant and the second depressant	and ation ived a 7 of CAA the s and and ation ived a 7 of CAA the s and a 18/13, and a s. Sluded a a rt start eric ere ant noce	F 329				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
	OVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	ATE, ZIP CODE	•		
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
	Wellbutrin, and Rememonitoring of the presspecific behaviors. During an observation resident #7 received a meal and ate the majidifficulty or episodes of the pressident #7 received a meal and ate the majidifficulty or episodes of the pressident #7 received of the same "modocument unusual be regardless of type of verified the facility lace resident #7's target be he/she received Cele Remeron. The facility failed to e receive unnecessary adequate monitoring evidence of monitoring behaviors/symptoms Celexa, Wellbutrin, and 483.35(i) FOOD PROSTORE/PREPARE/S The facility must - (1) Procure food from considered satisfacto authorities; and	eron, and then lacked sence/absence of those on 5/8/13 at 12:01 p.r. assistance to eat his/he ority of his/her meal with of depression. In 5/15/13 at 8:06 a.m., g Staff A reported the fixed and behavior" form shaviors for all residents medication received. Select evidence of monitoe haviors/symptoms who was, Wellbutrin, and sure resident #7 did not medications related to as the facility lacked g target while the resident received Remeron. ICURE, ERVE - SANITARY I sources approved or rry by Federal, State or stribute and serve food	m., er chout facility to s Staff A oring ile	F 329				
	This Requirement is	not met as evidenced b	oy:					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E627		B. WING		05/21/2013
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	
HODGEMAN COUNTY HEALT	H CENTER LTCU		AMLEY PO RE, KS 678		
PRÉFIX (EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETIO
one dining room who Based on observation review, the facility fas sanitary conditions of plates, bowls, and be contaminated glover practice affected 20 #26, 2, 22, 13, 9, 18 Findings included: - During observation 5/13/13 at 12:05 p.m. disposable gloves presidents and touch that other staff touch resident's choices, to table. Staff F failed gloves from his/her and 12:38 p.m., State contaminated gloves each of the 20 residents/her thumb, touch half, and placed the plates and served to 18, 23, 16, 25, and 18, 23, 16, 25, and 19 During an interview Dietary Staff Q reported to glove but used tong baked potatoes and and bowls on the ring eating surface. The facility's undate Practices" policy instant of the sanitary surface.	I a census of 21 residents are rece 20 residents ate means on, interview, and record ailed to serve food under when staff touched residents are potatoes with displayed and the counter of the lunch meal on the counter of the counter	e pers steam ated co.m. ce of vith ut in ts' 3, 9,	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/21	1/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE		
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 371				F 371			
	gloves after washing	struct staff to remove and replace with clean their hands, but instruc at be worn if raw food is					
	The facility failed to serve food under sanitary conditions when staff touched residents' plates, bowls, and baked potatoes with contaminated gloved hands.						
	483.60(c) DRUG REC IRREGULAR, ACT O	GIMEN REVIEW, REPO N	ORT	F 428			
		each resident must be e a month by a licensed	d				
	the attending physicia	report any irregularities an, and the director of ports must be acted up					
	The facility reported a	not met as evidenced bacensus of 21 with 10 runnecessary medicati					
	review, the facility fail consultant pharmacis when the pharmacist monitoring target beh nursing and attending	t identified drug irregula did not report the lack of aviors to the director of	of				
	Findings included:						
	- Resident # 10's Anr	nual MDS (minimum da	ıta				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE			
HODGEM	AN COUNTY HEALTH	I CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 428	set) dated 4/10/13 revisevere cognitive imparting assessment furth received 7 days of an anti-depressant medicassessment period. Resident #10's CAA (summary dated 4/10/loss/ dementia due to behavioral symptoms behaviors, mood/ berbecoming agitated an summary for psychotic resident developed acuse of Remeron (and and Xanax (an anti-al summary further reveconsultant pharmacis psychotropic medicated staff to decreen vironmental stimuli monitor for increasing and to provide reassum anxiety. Resident #10's 5/1/17 revealed a renewed of the remember of the	vealed the resident had airment and mild depression revealed the resident had airment and mild depression revealed the resident atti-anxiety and cations during the (care area assessment) at triggered for cognitive diagnosis of dementia with shaviors related to resident combative. The CAA ropic drug use identified dverse reactions due to anti-depressant medical example of the physician and att monitored the use of the case the resident's provide emotional supplementation of the cancer during times of the physician of the case the resident's provide emotional supplementation of the case the resident's provide and depression and depression and depression and depression and depression and depression and the physician of the case the resident's provide emotional supplementation of the case the resident's provide emotion of the case th	esion. ove come ent d the etion) f13 oport, in	F 428				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 428	forms lacked evidence behaviors they hoped use of Remeron and 2 resident #10 for the p specific behaviors. Resident #10 's mont completed on 2/22/12 6/26/12, 7/31/12, 8/28 11/28/12, 12/26/12, 1 4/23/13 lacked conce target behaviors for the Xanax. During an observation Resident #10 sat at the not exhibit any behave the administrative administrative staff A monitoring of target b residents, such as residents' received m Remeron and Xanax, date. Consultant D vedocument the discuss administrative nurses The facility failed to epharmacist identified monitoring of targeted #10, who received Residents and the rec	e staff identified the tar to control/improve with Xanax, and then monitoresence/ absence of the thly medication reviews 2, 3/28/12, 4/24/12, 5/23/12, 9/25/12, 10/31/12/22/13, 2/9/13, 3/29/13 rns related to monitoring use of Remeron and the control of the dining room table, and ioral symptoms or anxion 5/15/13 at 1:07 p.m., at he/she recently discuse nursing staff R and for the facility to docume havior/symptoms for sident #10, while the edications such as but could not recall the edications such as but could not recall the erified he/she failed to sion he/she had with A and R. Insure the consultant drug irregularities related to behaviors for Resider emeron and Xanax.	n the pred pred pred pred pred pred pred pre	F 428			
	data set) revealed the	3 Annual MDS (minimus resident had severely d no depression. It furt received 7 days of					

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/	21/2013
HODGEMAN COUNTY HEALTH CENTER LTCU 809				RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 428	anti-psychotic, anti-a medications during the Resident #9's CAA (a summary dated 1/5/1 cognitive loss/ deme behavioral symptoms pain. The summary sellusions, particularly and children. The suresident becomes an restless, anxious and stated resident #9 was drug related side effect Remeron and Xanax. Resident #9's nursing directed staff to assect changes, monitor for medications and to nuse of psychotropic of directed staff to provisupervisor for reside. Resident #9's 5/1/1 included renewed on a *Invega, (an anti-anximilligram) at noon a *Invega, (an anti-psychially with a diagnosis *Remeron (an anti-demig every day *Buspar, (an anti-demig every day *Resident #9's clinical behavior monitoring monitored for a varied monitored for a varied medications and the summary and th	inxiety, and anti- depressible look back period. care area assessment) 3 triggered for delirium ntia, psychosocial wellbs, psychotropic drug usestated resident #9 had y involving his/her pareummary further stated the ngry with staff, becomes detaarful. The summary as at high risk for developets due to the use of Inc. g care plan dated 3/12/sess and monitor behavior over sedation of monitor for side effects of drugs. The care plan furide frequent and consist nt #9. 3 physician order sheet ders for: kiety medication), 0.125 and in the evening yechotic medication), 6m is of unspecified psychotic depressant medication). Peressant medication) 15	n, eing, e and ents ne also oping vega, 13 or of the rther tent mg g sis. 30 5 mg eric cific to	F 428			

(X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BRA	ESS, CITY, STA MLEY PO RE, KS 678	BOX 367		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 428	forms lacked evidence behaviors they hoped use of Xanax, Invega then monitored reside absence of those special experience of the use of Remeron, In the use of	e staff identified the tar to control/improve with Remeron and Buspar ent #9 for the presence, cific behaviors. Ally medication reviews 2, 3/28/12, 4/24/12, 5/22/26/12, 9/25/12, 10/31/12/22/13, 2/9/13, 3/29/13 rns for target behaviors Buspar, Xanax and Inv. n on 5/14/13 at 10:50 a geled resident # 9 to his water to the resident, was or agitation noted. In 5/15/13 at 11:15 a.m. irmed that resident # 9 yays, could become very generally anxious and ard due to pacing in the taff C further revealed is same behavior sheet was that staff can put in a dents being monitored. In 5/15/13 at 1:07 p.m., d he/she recently discu- e staff R and administration to document monitorinatoms for residents, such resident received Remeron and Xanxax, ate. Consultant D verificant the discussion here	n the and / 2/12, , and s for egam., s/her with ., rbally lethat which s for ssed rative g of h as but sied	F 428			

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 428	The facility failed to e pharmacist identified monitoring of targeted who received Remerciance. - Resident #17's Quaset) assessment date resident had intact codelirium or hallucinatianti-psychotic and an Resident #17's CAA (dated 5/23/12 confirm psychotropic medicat. Resident #17's nursindirected staff to monitand psychological chaeffectiveness of Seromedication.) Resident #17's 5/1/13 revealed renewed ord: * Seroquel XR 50 mg atypical psychosis with Celexa 10 mg daily. Resident #17's clinical behavior monitoring formonitored for a variety resident #17. Review forms lacked evidency target behaviors they with the sue of Seroq monitor resident #17 those specific behavior.	nsure the consultant drug irregularities related behaviors for resident on, Buspar, Xanax and arterly MDS (minimum of 2/22/12 revealed the agnition, no depression, ons, and received ti-depressant therapy of (care area assessment) and resident #17's use of ions. In g care plan dated 5/4/1 for for significant physiciange, review and assessment (an anti-depressant and (an anti-depressant for depressive disorders for: In g (milligrams) daily for the behavioral disturbance for depressive disorders for the behavior monitor of the behavior monitor of the behavior monitor of the presence/absent for the presence/absent for the presence/absent disturbance of the presence/absent for the presence/absent disturbance of the presence of the pres	data data data data data data data data	F 428				

4PWM11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	17E627		B. WING		05/2	21/2013	
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
HODGEMAN COUNTY HEALTH C	CENTER LTCU		MLEY PO RE, KS 678				
PREFIX (EACH DEFICIENCY N	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428 Continued From page 5 completed on 2/22/12, 3 6/26/12, 7/31/12, 8/28/1 11/28/12, 12/26/12, 1/13 concerns for target behas Seroquel and Celexa. During an observation of resident #17 sat in his/h Pepsi. The resident did symptoms. During an interview on 5 Consultant D reported h with the administrative staff A for the facility to target behavior/symptom resident #17, while their medications such as Secould not recall the date he/she failed to docume had with administrative. The facility failed to enside he/she failed to docume had with administrative. The facility failed to enside he/she failed to enside the received Seroque. Resident #16's 3/14/11 data set) reported intact or behavioral symptoms anti-depressant and hypassessment period. Resident #16's 3/19/13 area assessment) summa was at risk for developing due to daily use of Rem Rozerem. The summa resident #16 shows min reactions such as mild sections such as mild sections such as mild sections.	3/18/12, 4/24/12, 5/12 12, 9/25/12, 10/31/12, 3/13, and 2/9/13 lack aviors for the use of on 5/8/13 at 8:25 a.m her room sipping on a d not exhibit any beha 5/15/13 at 1:07 p.m., he/she recently discusstaff R and administr of document monitoring ms for residents, such resident received eroquel and Celexa, lie e. Consultant D verificent the discussion he/ nurses A and R. Sure that resident #17 by medications related arget behaviors while quel and Celexa. 13 Annual MDS (mininated to the consultant properties of the consultant prope	ed ., avioral ssed rative g of h as but red /she did d to the mum cood ved the sare sident titions	F 428				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	ROVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	ESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 428	extremities. The facili routinely. Resident #16's 3/12/1 instructed staff to ass behavioral changes a behavioral flow sheet. Resident #16's 5/1/13 revealed a renewed of the facility failed to expend the facility failed to expend the facility failed to end of the facility failed to expend the facility failed the facility failed to expend the facility failed to ex	ity will continue to monital 2 nursing care plan less for mood and and document on mood or a physician 's orders order for: Repressant) 7.5 mg ressant) 20mg daily y medication reviews 2, 3/18/12, 4/24/12, 5/18/12, 9/25/12, 10/31/12, 1/3/13, and 2/9/13 lack rehaviors for the use of an on 5/8/13 at 12:15 p.m. and the dining room table, conversed with his/her of the dining room table, conversed with his/her to document monitoring toms for residents, such resident received Seroquel and Celexa, and ate. Consultant D verification the discussion here	and 2/12, , ed m., ssed rative g of h as but fied //she	F 428				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	the lack of evidence of behaviors while residence of Celexa, and Rozerem - Resident #6's Quarterial assessment date resident with moderal minimal depression, at Resident #6's 10/2/12 assessment) summar of psychotropic medical Resident #6's nursing directed staff to monitate and psychological charter effectiveness of the Lexapro. Resident #6's 5/1/13 a renewed order for: *Trazadone (an anti-of (milligrams) every nig * Lexapro (an anti-defective effective effect	of monitoring target ent received Remeron, n. terly MDS (minimum dad 3/18/13 identified the tely impaired cognition, and no behaviors. 2 CAA (care area ry noted the resident 's cations. 3 care plan dated 8/18/1 for for significant physicianges, to review and as the drugs Trazadone and physician 's orders review and as the drugs Trazadone and physician's orders review and as the drugs Trazadone and physician's orders review and as the drugs Trazadone and physician's orders review and as the drugs Trazadone and physician's orders review and as the drugs Trazadone and physician's orders reviews 2, 3/18/12, 4/24/12, 5/18/12, 9/25/12, 10/31/12/13/13, and 2/9/13 lack enaviors for the use of pro. In on 5/8/13 at 8:20 a.m. the elchair in the dining and meal and did not exite the care of the second processors.	use 12 cal ssess d ealed 2/12, ed ., room hibit	F 428				

	OF DEFICIENCIES CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	ESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 428	with the administrative staff A for the facility target behavior/symptoresident #6, while the medications such as a could not recall the data he/she failed to docur had with administrative. The facility failed to e not receive unnecess the lack of evidence of behaviors while reside Lexapro. - Resident #2's 5/7/1 included diagnoses of untrue persistent beliate person although evide anxiety (a mental or echaracterized by apprirrational fear) and defendings of sadness, we emptiness). Resident #2's 4/13/13 Data Set) Assessment impaired cognition, medications 7 of the 7 decived antipsychotic medications 7 of the 7 decived in the facility of the facility and the fa	e staff R and administre to document monitoring toms for residents, such resident received Seroquel and Celexa, ate. Consultant D verifiment the discussion heave nurses A and R. Insure that resident #6 cary medications related of monitoring target ent received Trazadone and the cary medication and the cary medication related of monitoring target ent received Trazadone and the cary medication rehension, uncertainty appreciately expected by exaggerate worthlessness and a Quarterly MDS (Minimat reported moderately ild depression, and reported the resident cand antidepressant robservation days.	g of h as but ied /she did d to e and ders n / a) with and ed hum	F 428	DEFICIENCY			
	Assessment) summar experienced delusion	B Behavior CAA (Care A ry reported the resident s related to stating his/ d parents being unable	t her					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FI LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
F 428	Continued From page	e 59		F 428				
	Drug Use CAA summ received an antidepre to little energy and por antipsychotic medicat. Resident #2's care plainstructed staff to more effects and/or adverse Risperdal (an antipsychemeron (an antidepreceded of the content of the c	an, last reviewed on 4/2 nitor for potential side e consequences for chotic medication) and ressant). signed physician's ordelers for Risperdal 0.25 rely for delusional disordert date of 4/4/12 and y every evening for rt date of 2/8/13. record included a geneorm on which staff by of behaviors which what #2. Review of residering forms lacked eviderget behaviors they hop the use of Risperdal or acked monitoring of the those specific behavior 2's pharmacy consultant eviews between 4/24/12 nentation that Consultant related to the facility's et behaviors/symptoms erdal, nor between 2/15	dent elated 25/13, ers mg er eric ere nt nce oed to es. 1 2 and nt D 6 9/13					
		n on 5/9/13 at 7:58 a.m his/her meal independe						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALT		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		` '	LE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
		CENTER LTCU	809 BR	AMLEY PO RE, KS 678	BOX 367	·		
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 428	conversed pleasantly mention of worries relunable to find him/her unable to find him/her During an interview or Consultant D reported with Administrative Not facility to document metabenavior/symptoms for resident #2, while the medications such as could not recall the doccurred. Consultant document the discuss director of nursing or nursing. The facility failed to econsultant reported in physician and the director facility's failure to target behaviors/sympreceived Risperdal are Resident #26's 5/7/included a diagnosis musculoskeletal pain, and severe sleep dist sudden overpowering (abnormal emotional exaggerated feelings and emptiness), and emotional reaction chapprehension, uncert Resident #26's 4/15/15 Status MDS (Minimur reported no cognition depression, and the resident propersion of the resident mention o	with staff, and made no lated to his/her family by r. In 5/15/13 at 1:07 p.m., d he/she recently discusursing Staff R and A for nonitoring of target for residents, such as residents received Risperdal and Remeror at the discussions to D verified he/she failed sion with either the previourent interm director of nursing related adequately monitor for ptoms while resident #2 and Remeron. It is signed physician's confidency plants of the properties of the attenuate of the properties of the prope	ssed or the ssed o	F 428				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	17E627		B. WING		05/	21/2013
NAME OF PROVIDER OR SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
HODGEMAN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
PRÉFIX (EACH DEFICIENC			ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AG CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
resident received no a during the observation. Resident #26's 4/25/1. CAA (Care Area Asse the resident received medication) for panic antidepressant medication. Resident #26's care p 4/25/13, instructed staside effects and/or adthe resident received a Clonazepam, and Rerincluded interventions and emotional support and monitor the effect medications. Resident #26's 5/7/13 included renewed orde 2/15/13 for Abilify 2 m treat panic disorder ar 60 mg orally twice a d fibromyalgia, and Clor three times a day to treat physician's orders included antidepressant medication. Resident #26's clinication and continued for a variety not specific to residen.	s. The MDS reported to antianxiety medication in period. 3 Psychosocial Well-bressment) summary reported to antianxiety medication in period. 3 Psychosocial Well-bressment) summary reported to antipsychotic attacks, Cymbalta (an ation) for depression and Clonazepam (an in) for anxiety. Idan, last reviewed on aff to monitor for possible verse consequences were abilify, Cymbalta, meron. The care plan is to allow the resident tit during times of distrestiveness of pain 4 signed physician's orders with start dates of and fibromyalgia, Cymbalta (milligrams) orally dated fibromyalgia, Cymbalta (milligrams) orally dated orders for Remededication) 7.5 mg orally the Clonazepam to 0.5 mg orally and at noon and 1 mg in all record included a gental record included a ge	eing orted ic and ole while ime ss ders aily to alta and y 3 ron y at ng in the ineric rere ent	F 428			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	that staff identified tar improve/control with the Clonazepam, or Rem monitoring of the presspecific behaviors. Review of resident #2 monthly medication reduzable to the direct	rget behaviors they hop he use of Abilify, Cymberon, and then lacked sence/absence of those 26's pharmacist consultateviews between 2/19/13 isultant D failed to reported to lack of monitor potoms while the resider balta, Clonazepam, or an on 5/9/13 at 8:13 a.m. If his/her meal independent signs of distress. In 5/15/13 at 1:07 p.m., dependent of he/she recently discusturing Staff R and A for nonitoring of target for residents, such as the residents received Abilify, Cymbalta, the eron, but could not reconcurred. Consultant Extended to document the discustured in the consultant of t	ant's ant's and rt the ring nt ., lently ssed r the ding to	F 428				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU		ESS, CITY, STA MLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 428	- Resident #22's 5/7/ included diagnoses of mental disorder charac confusion) with behave depression (abnormal characterized by exags sadness, worthlessness, worthlessnessnessnessnessnessnessnessnessness	13 signed physician's of dementia (progressive acterized by failing menyioral disturbances and I emotional state ggerated feelings of ess and emptiness). 13 Quarterly MDS (Minint reported no cognition of depression, no haviors. The MDS reporantipsychotic and eations 7 of the 7 observations 10 of 12 Delirium CAA (Care ammary reported the resident returned rm care facility with a secondary to a urinary 17 ADL (Activities of Dr. Apple 18 of 19 of 1	mum orted vation e ares, to an on tract vaily ut the tern viors	F 428				

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			E CONSTRUCTION	(X3) DATE SUF COMPLET	
		17E627	,	B. WING		05/2	1/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE		
HODGEM	AN COUNTY HEALT	'H CENTER LTCU		AMLEY POI RE, KS 6785			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY I DR LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 428	antidepressant medical	dication). e plan, last reviewed on staff to monitor potential ree consequences while exapro, Trazadone, and plan instructed staff to ms in his/her mood and to on the "mood and behan instructed staff to monitated to dementia. In's orders included rene 20 mg (milligrams) orally 12/28/11, Trazadone 25 th an as needed order for hour after the scheduled 12/4/12, and Zyprexa 5 in the a start date of 2/8/13. Ical record included a get form on which staff lety of behaviors which went #22. Review of residultoring forms lacked evicating forms lacked evicating forms lacked evicating the use of Lexapro, prexa, and then lacked resence/absence of those which is the use of Lexapro, prexa, and then lacked resence/absence of those staff lety of behaviors they hope the use of Lexapro, prexa, and then lacked resence/absence of those staff lety of behaviors while the residular reviews between 2/22/11 lence that Consultant Desides to the director of nursing physician related to lace the director of sure physician	e the to aviors" itor for ewed / daily mg or an I dose mg eneric were dent dence ped to se Itant's 12 and sing ck of ident .	F 428			
	During an observati	ion on 5/8/13 at 8:18 a.m	n.,				

4PWM11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	21/2013	
	OVIDER OR SUPPLIER AN COUNTY HEALTH	CENTER LTCU	809 BR	RESS, CITY, STA AMLEY PO RE, KS 678	BOX 367			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 428	resident #22 received meal and ate the maje difficulty or episodes of During an interview of Consultant D reported with Administrative Net facility to document methodological behavior/symptoms for resident #22, while the medications such as a Zyprexa, but could not discussions occurred he/she failed to docur either the previous director of nursion that the facility failed to econsultant reported in physician and the director of the facility's failure to target behaviors/sympreceived Lexapro, Transcript Data Set) Assessment cognition, minimal dedelusions. The MDS repartipsychotic and antithe 7 observation day	assistance to eat his/reprity of his/her meal with of crying or screaming on 5/15/13 at 1:07 p.m., dependently discussing Staff R and A for an incident for residents, such as the residents received Lexapro, Trazadone, and trecall the date the consultant D verified ment the discussion with rector of nursing or currising. Insure the pharmacist regularities to the attendent the discussion with rector of nursing related adequately monitor for othoms while resident #2 azadone, and Zyprexa. It is a signed physician's or of depression (progress acterized by failing mental treported severely impression, and experient reported the resident haviors toward others a days during the observance of the resident received the resid	hout out. ssed the ding to 22 ders sive nory, num paired ced and ation ived i 7 of	F 428				

Printed: 05/21/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIE AND PLAN OF CORRECT		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE			LE CONSTRUCTION	(X3) DATE SU COMPLET	
		17E627		B. WING		05/2	21/2013
NAME OF PROVIDER OR	SUPPLIER		STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	· · · · · · · · · · · · · · · · · · ·	
HODGEMAN COU	NTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
(Care A resident staff mo adverse Resider instructe provide experier instructe effects a resident Resider renewed medicat * Celex start dat * Wellb date of £ * Remedate of £ * Resider behavior monitore not specific Review monthly 4/23/13 irregular attendin	received ant initored for poor reactions. It #7's care pled staff to assign quality listen inced crying elect staff to more and adverse of received ant in the theoretical transport of the transpo	e 66 ent) summary reported idepressant medication idential side effects and an, last reviewed on 3/2 less for mood changes ing time if the resident pisodes. The care plannitor for potential side consequences while the idepressant medication physician's ordered incorree antidepressant igrams) orally daily with a star graph of the properties of the prope	as and 18/13, and as s. cluded a a rt start eric ere ent nce bed to et 's and ort or the ring	F 428			

(X2) MULTIPLE CONSTRUCTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER HODGEMAN COUNTY HEALT		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	ATE, ZIP CODE	•	
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678			
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 428				F 428			
	received Celexa, Wel	lbutrin, and Remeron.					
	During an observation on 5/8/13 at 12:01 p.m., resident #7 received assistance to eat his/her meal and ate the majority of his/her meal without difficulty or episodes of depression.		er				
	During an interview on 5/15/13 at 1:07 p.m., Consultant D reported he/she recently discussed with Administrative Nursing Staff R and A for the facility to document monitoring of target behavior/symptoms for residents, such as resident #7, while the residents received medications such as Celexa, Wellbutrin, and Remeron, but could not recall the date the discussions occurred. Consultant D verified he/she failed to document the discussion with either the previous director of nursing or current interm director of nursing.		r the				
	physician and the dire the facility's failure to target behaviors/symp	regularities to the atten ector of nursing related adequately monitor for ptoms while resident #7 lbutrin, and Remeron.	to				
	483.65 INFECTION O SPREAD, LINENS	CONTROL, PREVENT		F 441			
		gram designed to provid mfortable environment a evelopment and					
	Program under which	blish an Infection Contr					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB		` ′	CONSTRUCTION	(X3) DATE S COMPL	
		17E627		B. WING		05	/21/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STATE	, ZIP CODE	•	
HODGEM	AN COUNTY HEAL	TH CENTER LTCU		RAMLEY PO BORE, KS 67854			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUL REGULATORY OR LSC IDENTIFYING INFORMATIO		ULL	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 441	should be applied (3) Maintains a recactions related to i (b) Preventing Spr (1) When the Infect determines that a represent the spread isolate the residen (2) The facility must communicable disc from direct contact will to the facility must hands after each do hand washing is in professional practic. (c) Linens Personnel must has	procedures, such as isolar to an individual resident; cord of incidents and corresponding to a finite tion. The ead of Infection resident needs isolation to a finite tion, the facility in the faction, the facility in the ease or infected skin lesion with residents or their formal the disease. The ease of	and ective nust ons od, if eir which	F 441			
This Requirement is not not not facility reported a cen							
	review, the facility environment and p transmission of dis residents residing	assed on observation, interview, and the record eview, the facility failed to maintain a sanitary environment and prevent the development and ansmission of disease and infection for esidents residing in the long term care unit when taff failed to effectively sanitize toilets.					
	Findings included:						
	_	vation on 5/8/13 at 8:47 a					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		17E627		B. WING		05/2	1/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADDR	ESS, CITY, STA	TE, ZIP CODE	•		
HODGEM	AN COUNTY HEALTH	CENTER LTCU		AMLEY PO RE, KS 678				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	cleaner into resident at the bathroom and flus remained in the toilet. The label on the contadirected the user to lefor a minimum of 10 reffective sanitization. Although requested, the policy for sanitization. During an interview of housekeeping staff Houlet approximately 3 Dispatch to the toilet. lacked awareness of Dispatch cleaner in the minutes in order to error on 5/14/13 at 10:00 are ported he/she expedepartment to follow the bottle. The facility failed to menvironment in order and transmission of distaff failed to follow the	# 2's toilet. He/she clease hed the toilet. The clease hed the toilet. The clease hed the toilet. The clease hed the familiary failed to prove the facility failed to prove the flushed minutes after adding the requirement to leave the facility and failed the house keeping the instructions control stated the house keeping the instructions listed on the facility to prevent the developing the manufacturer's ensure effective sanitizers.	aner toilet ure ride d the o the of the original	F 441				